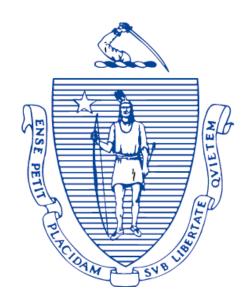# Commonwealth of Massachusetts
Executive Office of Health and Human Services

March 2008
v2.0

Health Safety Net Office
Companion Guide for
Dental Claims
For ASC X12N 837D (version 4010A1)
For Health Safety Net Providers
in the CHC Setting

Table of Contents

1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 — Administrative Simplification (HIPAA-AS) among other things, created a set of electronic data interchange standards for health care as established by the Secretary of Health and Human Services (HHS). HHS has adopted an Implementation Guide for each standard transaction. Version 0004010X097A1 of the 837 Dental transactions is the standard established by HHS for institutional claims submission.

1.2 Purpose of the Implementation Guide

The Implementation Guide for the 837D claim transaction specifies in detail the required formats for claims submitted electronically. The implementation guide contains requirements for use of specific segments and specific data elements within the segments, and was written for all health-care providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files to HSN.

1.3 How to Obtain Copies of the Implementation Guides

The 837D Implementation Guide for X12N 837 version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA. HSN Specific Implementation Guides for each claim type are available for download at www.mass.gov/healthsafetynet.

1.4 Purpose of This Companion Guide

This 837 Companion Guide was created for HSN trading partners by HSN to supplement the 837 Implementation Guide. It contains HSN-specific instructions for the following:

• Data content, codes, business rules, and characteristics of the 837 transaction;
• Technical requirements and transmission options; and
• Information on testing procedures that each trading partner must complete before submitting 837 claims.

The information in this guide supersedes all previous communications from HSN about this electronic transaction. The following policies are in addition to those being outlined in the HSN provider manual for individual claim types. These policies in no way supersede HSN regulations.

The 837D Implementation Specifications are only the elements that HSN requires, when appropriate. Providers may submit additional loops and segments beyond the specification without any implications.

1.5 Intended Audience

The intended audience for this document is the technical staff responsible for submitting electronic 837 claims to HSN. In addition, this information should be shared with the provider's Registration Department, Medical Records and Billing Office to ensure that all required billing information is available for claim submission.

2.0 Establishing Connectivity with HSN

HSN uses Sends/iNet to act as the gateway between provider and claims processor.

2.1 Setup

All HSN trading partners must sign a Trading Partner Agreement (TPA) and will be requested to complete a trading partner profile (TPP) form before submitting electronic 837 transactions. Note that TPP information may be given over the telephone in lieu of completing a paper form. If you have already completed these forms, you do not have to complete them again. Please contact HSN Help Desk at 1-800-609-7232 if you have any questions about these forms.

HSN trading partners must submit HIPAA 837 claims to HSN via the Sends/iNet process. All test files submitted through iNet require that the provider select the 837 Test option, otherwise the file will be treated as Production.

After establishing a transmission method, each trading partner must successfully complete testing. Information on this phase is provided in the next section of this companion guide (see Section 2.2: Trading Partner Testing). After successful completion of testing, 837 transactions may be submitted for production processing.

All test files should also have these following elements:
ISA15 = T (Test)
GS08 = 004010X97A1
REF02 = 004010X97A1

Hard media will not be accepted.

2.2 Trading Partner Testing

Before submitting live 837 claims to HSN, each trading partner must be tested. All trading partners who plan to submit 837 transactions must contact HSN Help Desk at 1-800-609-7232 in advance to discuss the appropriate updates to SENDS/INET for 837 submissions.

Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction. If you are a first-time submitter:
• We require a file with a minimum of 10 test claims, there is no maximum limit.
• The patient and provider data must be valid for a mutually agreed upon effective date.

The following conditions must be addressed in one or more test files:
The test files should contain as many types of claims as necessary to cover each of your business scenarios.
• Original claims;
• Void claims (if you plan to submit void claims; last digit of Type of Bill should be 8);
• Replacement claims (if you plan to submit void transactions and replacement claims; last digit of type of Bill should be 7); and
• Coordination of benefits claims (COB, if you plan to submit COB claims).

> ***NOTE: In order to test the Validity of the Void and Replacement functionality, providers will have to submit one claim file with Originals first.***

Providers submitting test files containing COB claims (where the patient has other insurance) should include a minimum of 10 COB claims with the following criteria:

• Claims with commercial insurance (denied/paid);
• Claims with Medicare (denied/paid);
• Claims with Medicaid (denied/paid);
• Claims with multiple insurance, if applicable; and

All test files, regardless of the type of services provided, should be submitted using the naming convention as supplied by the SENDS software. Do not alter the file name, as this will cause submission errors

HSN will process these transactions in a test environment to validate that the file structure and content meet HIPAA standards and HSN-specific data requirements. Once this validation is complete, the trading partner may submit production 837 transactions to HSN for adjudication. **Test claims will not be adjudicated.**

2.3 Technical Requirements
There is no current maximum file size for any 837 file submitted to HSN. HSN endorses the ASC recommendation that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5,000 CLM segments. **There can only be one instance of an ST-SE transaction within a GS-GE or ISA-IEA.**

2.4 Acknowledgements
Confirmation numbers are generated for all 837 transaction files uploaded to the Web portal, indicating file upload status. 837 files submitted to HSN that fail syntactical accuracy will produce a TA1 interchange acknowledgement only. 837 files submitted to HSN that pass interchange acknowledgements will produce a 997 file acknowledgement. These acknowledgements will be available for download from the transactions Web site.

HSN uses the tilde (~) segment terminator on all outbound HIPAA-compliant transactions. HIPAA-compliant outbound transactions from HSN include the 835 electronic remittance advice transactions and the 997 acknowledgements.

2.5 Support Contact Information
Health Safety Net Help Desk
Phone: 1-800-609-7232

Health Safety Net 837D Companion Guide v2.0

3.0 Health Safety Net - Specific Submission Requirements
The following information is for production claims. For test claims refer to the Trading Partner Testing section.

The following sections outline recommendations, instructions, and conditional data requirements for 837 claims submitted to HSN. This information is designed to help trading partners construct the 837 transactions in a manner that will allow HSN to efficiently process claims.

3.1 Claims Attachments
HSN does not accept electronic Claims Attachments.

Should HSN require additional documentation to process a claim, that claim will be suspended for 30 days to allow for a submission period of supporting documentation. Claims that were suspended and were not matched to submitted documentation within 30 days will process as denied.

Periodically, HSN may ask providers to verify the completion of attachments kept on file. In cases where HSN reviews have revealed provider noncompliance with the recordkeeping requirements

Medical Hardship claims may require hard-copy documentation to be submitted into HSN prior to the Claim being submitted for processing. Please review 114.6 CMR 13.05 (1-7) for Application process and Claim submission requirements.

3.2 Encounter Claims
HSN does not accept encounter claims. For further details, see Section 3.6: Detail Data
.
3.3 Coordination of Benefits (COB)
The implementation of the 837 transaction enables providers to submit claims for patients with other insurance electronically to HSN, after billing all other resources. Claims where HSN is the secondary payer or the patient has Medicare supplemental insurance must be submitted to HSN by the provider. Providers must submit claims adjudicated by Medicare to HSN because there is no agreement between HSN and the Medicare fiscal intermediary or carrier. When submitting an 837 transaction to HSN for patients with other insurance, providers must supply the other payer's adjudication details that were provided on the 835 remittance transaction along with the Health Care Finance & Policy Payer ID. Providers are required to enter the other payer's adjudication details at the claim level. The adjustment reason codes entered in the COB loops should be the exact codes given by the other payer. Altering the adjudication details given by the other payer is considered fraudulent.

In addition, HSN requires providers to enter the assigned carrier code on the 837 transaction to identify the other insurance.

3.3.1 COB Bundled Claims
HSN will process claims for services that are bundled by a commercial insurance or Medicare as a bundled claim.

3.4 Void and Replacement Transactions
Please Note: Under HIPAA guidelines, adjustments to paid claims should be submitted as a void or a replacement transaction.
Void transactions are used by submitters to correct and report any one of the following situations:

- Duplicate claim erroneously paid;
- Acknowledgment / Payment to the wrong provider;
- Acknowledgment / Payment for the wrong patient;
- Acknowledgment / Payment for services for which payment was received from third-party payers after HSN processing of claim

Replacement transactions are used by submitters to correct and report any one of the following situations:
- To add Late Charges to a claim
- To remove Charges from a claim
- To correct any component of a claim (subscriber/patient demographics as well)

3.5 Production File-Naming Convention

837D files, regardless of the type of services provided, should be submitted using the naming convention as supplied by the SENDS software. Do not alter the file name, as this will cause submission errors

All Production files must have these following elements:
ISA15 = P (Production)
GS08 = 004010X97A1
REF02 = 004010X97A1

Hard media will not be accepted (e.g., paper claims, magnetic media).

3.6 Detail Data

HSN recommends that submitters pay special attention to the following segments as these segments have already generated questions. Some of these are required segments and others are situational or optional, please see the 837D Implementation Specification document to see the required segments.

CHANGES since the last posting are high-lighted in YELLOW.

Loop	Segment		Element Name	Companion Information
----	ISA	05	Interchange Sender ID Qualifier	Enter "ZZ."
----	ISA	06	Interchange Sender ID	Enter Provider HSN Organization ID This will be treated as the Pay-To identifier by HSN.
----	ISA	07	Interchange Receiver ID Qualifier	Enter "ZZ."
----	ISA	08	Interchange Receiver ID	Enter "HSN3644"
----	ISA	15	Interchange Usage Indicator	This element is used to indicate whether the transmission is in a test or production mode. A "P" indicates production data, and a "T" indicates test data.
----	GS	02	Application Sender's Code	Enter Provider HSN Organization ID
----	GS	03	Application Receiver's Code	Enter "HSN3644"

Health Safety Net 837D Companion Guide v2.0

----	BHT	02	Transaction Set Purpose Code	When submitting the 837 batch for the first time this code must equal 00 (Original). If resubmitting the file due to an issue like disrupted transmission, this code must equal 18 (Reissue).
----	BHT	06	Transaction Type Code	In the Beginning of Hierarchical Transaction (BHT) loop, BHT06 should always be equal to "CH," and all submitted 837 transactions should be claims for payment. A set of encounters, indicated by BHT06 equal to "RP," will pass compliance checks but no transactions within the set will be released to the adjudication system.
1000A	NM1	09	Submitter Identification Code	Submitter's Organization ID Number. This will be used as the Pay-To Organization ID Number.
1000B	NM1	09	Receiver Identification Code	Enter "HSN3644"
2000B	SBR	03	Reference Identification	DO NOT USE
2000B	SBR	04	Name of Destination Plan	Enter one of six HSN Types: Prime, Second, Partial, BD, CA or MH. Prime = When HSN is the only payer Second = When HSN is secondary to any other payer (includes when Primary payer denies) Partial = When HSN is accepting the claim based upon Federal Poverty Level of the patient BD = ER Bad Debt Claim CA = Confidential Application Claim MH = Medical Hardship Claim
2000B	SBR	09	Subscriber Information Claim Filing Indicator Code	Enter "ZZ" for HSN Types = Prime, Second, or Partial Enter "09" for HSN Types = BD, CA or MH
2010BA	NM1	08	Identification Code Qualifier	Enter "MI" for Member Identification Number **Required**
2010BA	NM1	09	Identification Code	Enter the MassHealth Recipient ID Number if available. If unavailable, enter any information that aids in identifying unique patient. **Required** Utilize when SBR02 = 18 (Self)

Health Safety Net 837D Companion Guide v2.0

2010BA	REF	01	Subscriber Identification Code Qualifier	Enter "SY" for Social Security or Individual Tax ID ember ID Number. HSN utilizes Social Security Number or Individual Tax Identification Number as the member identification.
2010BA	REF	02	Identification Code	Enter the Subscriber's Social Security Number or Individual Tax Identification Number. When there is no SSN or TIN to submit enter "000000001".
2010BB	NM1	08	Payer Identification Code Qualifier	Enter "PI"
2010BB	NM1	09	Payer Identification Code	Enter "995" for HSN Payer ID
2000C	HL	02	Hierarchical Parent ID Number	Data element changed from "Not Required" to "Required"
2010CA	NM1	08	Identification Code Qualifier	Enter "MI" for Member Identification Number **Required if this loop is utilized**
2010CA	NM1	09	Identification Code	Enter the MassHealth Recipient ID Number if available. If unavailable, enter any information that aids in identifying unique patient. **Required** Utilize when SBR02 is not reported
2010CA	REF	01	Patient Secondary Reference Identification Qualifier	Enter "SY" for Social Security or Individual Tax ID ember ID Number. HSN utilizes Social Security Number or Individual Tax Identification Number as the member identification.
2010CA	REF	02	Patient Secondary Reference Identification	Enter the Subscriber's Social Security Number or Individual Tax Identification Number. When there is no SSN or TIN to submit enter "000000001".
2010CA	DMG	01	Date Time Period Format	Enter 'D8' for date formatted as CCYYMMDD
2010CA	DMG	02	Date Time Period (Patient's Birth-date)	The patient's birth date is a requirement for processing.
2010CA	DMG	03	Gender Code	Only one of three codes are allowed and is required: F = Female; M = Male; U = Unknown
2300			Claim Information	There is no limit to the number of claims submitted at this time.
2300	CL1	03	Patient Status Code	Required for all inpatient claims.
2300	CLM	05-1	Claim Information Facility Code Value (Facility Type Code)	The 837 format uses the first two characters of Bill Type to establish place of service for the entire claim.

2300	CLM	05-3	Claim Frequency Type Code	The HSN will only accept Claim Frequency types of 1 = Original Claim 7 = Replacement of Prior Claim 8 = Void of Prior Claim Frequency Type 5 is not allowed. Submitters are not required to submit a Void claim first in order to submit a Replacement claim.
2300	AMT	01/02	Patient Estimated Amount Due	If there is a patient paid amount associated with the services provided, enter "F3" in REF01 and the amount of the patient paid amount in REF02.
2300	REF	01/02	Prior Authorization or Referral Number	HSN does not provide Prior Authorization or Referral Numbers at this time. However, if billing HSN as Secondary to another insurance that had a Prior Authorization or Referral Number, that information must be on the claim.
2300	HI	01-2	Occurrence Information Industry Code (Identifier BH)	REQUIRED FOR ER BAD DEBT CLAIMS. Submitters of ER Bad Debt Claims are required to file an Occurrence Code for the Write-Off Date of the claim. The Occurrence Code is equal to the Effective Date utilized by the National Uniform Billing Committee. This can be A2, B2 or C2 dependent upon where HSN is identified as the destination payer on the claim.
2300	HI	01-2	Value Information Industry Code (Identifier BE)	REQUIRED FOR ER BAD DEBT CLAIMS. Submitters of ER Bad Debt Claims are required to file an Value Code for the Write-Off Amount of the claim. The Value Code is equal to the Estimated Responsibility Code utilized by the National Uniform Billing Committee. This can be A3, B3 or C3 dependent upon where HSN is identified as the destination payer on the claim.
2310B	NM1	08	Rendering Provider Identification Code Qualifier	Enter "XX" for National Provider Identification Number
2310B	NM1	09	Rendering Provider Identification Code	Enter the Rendering Provider's National Provider Identification Number
2310B	REF	01	Rendering Provider Reference Identification Qualifier	Enter "0B" for Board of Registry in Medicine Number

Health Safety Net 837D Companion Guide v2.0

2310B	REF	02	Rendering Provider Reference Identification	Enter the Rendering Provider's BORIM Number **Required**
2310C	NM1	08	Service Facility Identification Code Qualifier	Enter "XX" for National Provider Identification Number
2310C	NM1	09	Service Facility Identification Code	Enter the National Provider Identification Number of the Service Facility
2310C	REF	01	Service Facility Reference Identification Qualifier	Enter "LU" for Location Number **Required**
2310D	REF	02	Service Facility Reference Identification	Enter the Organization ID Number of the Service Facility **Required**
2330A	REF	01	Other Subscriber Reference Identification Qualifier	Enter "SY" for Social Security or Individual Tax ID ember ID Number. HSN utilizes Social Security Number or Individual Tax Identification Number as the member identification.
2330A	REF	02	Other Subscriber Reference Identification	Enter the Subscriber's Social Security Number or Individual Tax Identification Number. When there is no SSN or TIN to submit enter "000000001".
2330B	NM1	08	Other Payer Name Identification Code Qualifier	Enter "PI" for Payer Identification
2330B	NM1	09	Other Payer Name Identification Code	Enter the EDI Payer ID number if applicable This is a pre-existing list.
2330B	REF	01	Other Payer Reference Identification Qualifier	Enter "2U" for Payer Identification Number
2330B	REF	02	Other Payer Reference Identification	Enter the DHCFP Payer ID Number This is a pre-existing list. Available on HSN website
2330C	REF	01	Other Payer Patient Reference Identification Qualifier	Enter "SY". HSN utilizes Social Security Number or Individual Tax Identification Number as the member identification.
2330C	REF	02	Other Payer Patient Reference Identification	Enter the Subscriber's Social Security Number or Individual Tax Identification Number. When there is no SSN or TIN to submit enter "000000001".
2400	SV3	02-3, 02-4, 02-5, 02-6	Procedure Modifier	Modifiers are situational by use. If the Service Line is required to have a modifier, then the modifier must be present in order to pass edits in the Grouper. Only modifiers accepted by Medicare will be processed.
2400	DTP	01, 02	Service Line Date	User Option changed from Required to Situational as this is an Outpatient or reporting necessary drug administration dates on Inpatient claims.

Health Safety Net 837D Companion Guide v2.0

3.7 Detail Data for COB Claims

Loop	Segment		Element	Companion Information
2330B	NM1	08	Identification Code Qualifier	Enter "PI" for payer identification.
2330B	NM1	09	Other Payer Primary Identifier Code	Enter one of the Health Care Finance & Policy Payer ID when NM108 is "PI"

3.7.1 COB Crosswalk

Data Element Name	Destination Payer Location Loop | Segment	Other Payer Location Loop | Segment Element
Subscriber Last Name	2010BA | NM103	2330A | NM103
Subscriber First Name	2010BA | NM104	2330A | NM104
Subscriber Middle Name	2010BA | NM105	2330A | NM105
Subscriber Suffix	2010BA | NM107	2330A | NM107
Subscriber Identification Number	2010BA | NM108 / NM109	2330A | NM108 / NM109
Subscriber Street Address 1	2010BA | N301	2330A | N301
Subscriber Street Address 2	2010BA | N302	2330A | N302
Subscriber City	2010BA | N401	2330A | N401
Subscriber State	2010BA | N402	2330A | N402
Subscriber ZIP Code	2010BA | N403	2330A | N403
Payer Name	2010BC | NM103	2330B | NM103
Payer ID	2010BC | NM108 / NM109	2330B | NM108 / NM109
Patient Identification Number	2010CA | NM108 / NM109	2330C | NM108 / NM109
Relationship of Subscriber to Patient	2000B | SBR02	2320 | SBR02
Assignment of Benefits Indicator	2300 | CLM08	2320 | OI03
Patient's Signature Source Code	2300 | CLM10	2320 | OI04
Release of Information	2300 | CLM09	2320 | OI06
Prior Authorization / Referral Number **(Claim Level)**	2300 | REF01 / REF02	2330C | REF01 / REF02 of Prior Authorization / Referral Number REF.
Provider Identification Number(s) **(Claim Level)**	2310A-E | REF01 / REF02	2330D-H | REF01 / REF02 of other Payer Provider Identifiers / Not Required
Payer Specific Amounts	No Elements	All AMTs in the 2320 loop are specific to the payer identified in the 2330B loop of that iteration of the 2320 loop.

3.8 Additional Information

HSN does not process certain loops that do not apply to the HSN business model. For example, HSN does not process *2010BB Credit/Debit Card Account Holder Name* since HSN is not a Payment Processor. In certain circumstances, these loops may be required in a compliant 837 transaction.

Segments not required by HSN but submitted regardless, will be processed for compliance by the HIPAA Translator. Requirements from the HIPAA Translator will take precedence in these situations.

The data content of these loops will not affect the HSN claims process.

3.9 Service Codes

Please consult the AMA and NUBC reference publications for information on acceptable revenue, procedure and service codes. This information is also available on the Web.
HSN will continue to use the same Payer Codes as previously established

11

4.0 Version Table

Version	Date	Section/Pages	Description
1.0	1/15/08	Entire Document	Document is a mimic of the 837I Companion Guide with changes for HSN
2.0	3/14/08	Entire Document	Change HSN to HSN, account for 837D differences in Loop Structure and requirements

Appendix A: Frequently Asked Questions

Q: How can I receive 997 functional acknowledgements for rejects at the claim level rather than the transaction-set level?
A: The 997 acknowledges rejection of all claims within the ST/SE boundary. The only way to receive a 997 rejection for each invalid claim is to submit your 837s with only one claim per transaction set.

Q: Can providers use a third-party vendor to perform claims submissions for them?
A: Providers can use a third-party vendor to submit their claims files. The vendors need to follow the same sign-up procedure that the provider used in order to gain access to SENDS/iNet. It is recommended that the Provider obtain the SENDS/iNet agreements and fill them out for their vendor, have them signed and then submitted into the Division of Health Care Finance & Policy for log-on creation.

Q: When applicable, should I use the place-of-service codes contained in the HIPAA Implementation Guide when submitting HSN paper claim forms too?
A: HSN does not accept paper claims; please call the HSN Help Desk 1-800-609-7232

Q: What are the characters used to separate the various elements within the 837?
A: The HSN is using the asterisk (*) to separate data elements within segment and the tilde (~) as the segment terminator. Each segment must be followed by a carriage return line feed so that the elements are not bundled together.

Q: HSN has allowed outpatient departments that perform dental procedures to use the CDT codes and the CPT codes for oral surgery services. The 837D Implementation Guide states that CDT codes are the only service codes allowed when filing an electronic claim. What is the process for an outpatient department to submit claims for oral surgery services using a CPT code?
A: HSN requires that any and all services performed in the Acute Inpatient and/or Outpatient setting be included in the 837I claim for the patient. This includes Dental and Professional Services.

Q: How does a provider report Professional and/or Dental services on the 837I?
A: Providers should use the Professional Revenue Code ranges developed by the National Uniform Billing Committee of 096x, 097x and 098x to report specific Professional services, if they are billing them. All Dental HCPCS are to be reported using Revenue Code 512.

Q: Why does HSN require both NPI and BORIM numbers for any Physician appearing on a claim? Isn't the NPI enough information to identify the provider?

12

A: The BORIM number requirement is in place due to the complexity of the way providers applied for NPIs. The BORIM number identifies the actual provider of service to HSN where, depending on how the NPI was filed may not provide the person vs. non-person entity identification.

Q: How can a provider submit a claim with a Social Security or Individual Tax Identification Number requirement if the patient is an Undocumented Patient?
A: Providers are allowed to utilize the following number (a dummy number) if the patient has neither a Social Security nor Individual Tax Identification Number: 000000001.

Q: How will HSN determine Eligibility if I submit claims with 000000001 and there is a name mismatch with REVS?
A: Providers are encouraged to report the MassHealth Recipient ID Number in the Patient NM109 element. When 000000001 appears, the system will look for the MassHealth RID Number in this element to continue its Eligibility match.

Q: If I identify other insurance that is not on file with HSN, how do I submit the claim?
A: Follow the standard process for any coordination of benefits (COB) claim. To obtain the Division's assigned carrier code, cross reference the insurance name with the appropriate carrier code and enter the first three digits of the code on your 837 transaction. Concurrently, you should request that the HSN Payer ID file be updated by speaking with a HSN Help Desk representative at 1-800-609-7232

Q: Does HSN want their Payer Codes or the National Plan ID codes when submitting Secondary Claims?
A: HSN requires that the Providers submit the Health Care Finance & Policy Payer IDs at this time.

Q: Does the current 837I have a claim volume limitation of 100 like other payers?
A: The HSN does not require that a limitation be placed on the number of claims within the ST/SE envelope. However the file must have at least one claim in order to be processed.

Q: We currently submit a monthly file to UCP. Can the providers continue with this schedule?
A: HSN Claim submission scheduling is a business decision that needs to be determined by the provider. However, with the new regulations in regards to timely filing and the ability to post denials into provider collections systems via the 835, providers are encouraged to submit on a weekly basis. This will allow denied claims to be posted, reviewed for resubmission and re-submitted in a timely manner.

Q: Do providers still report Value Code PE when submitting ER Bad Debt Claims?
A: Providers are not to use the PE Value Code for HSN Claims. The claim must have the HSN type of BD identified in the Subscriber loop of the 837I. Then apply Occurrence Code A2, B2 or C2 (dependent on the line HSN is the Destination Payer on the claim) and the date of write-off. The claim must also have a Value Code of A3, B3 or C3 (to match Occurrence Code) with the amount written-off to Bad Debt.

Q: What about Value Code PF for Free Care claims?
A: The HSN does not use this code to identify these claims. The HSN Type options of Prime, Second and Partial are to be used now and reported in the Subscriber loop of the 837I. This in addition to the Amount fields used in the 837I, allow the HSN to obtain the appropriate values.

Appendix B: Provider Types to Invoice Types Map

If you are this Provider Type….	and currently submit this type of claim…	and billing this allowable service…	Then use this HIPAA Transaction or Billing Function*.
Acute Outpatient Hospital	UCP UB92	Acute Outpatient Services, Physician Services, Dental Services, Psychiatric Services	837I
Acute Inpatient Hospital	UCP UB92	Acute Outpatient Services, Physician Services, Dental Services, Psychiatric Services	837I
Community Health Center	UCP MA-9	Medicine CPTs	837D
Community Health Center	UCP MA-9	Dental CDTs	837D
Pharmacy	UCP UB92	NCPDP	POPS

Appendix C: Links to Online HIPAA Resources

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)

• ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Hospital Association Central Office on ICD-9-CM (AHA)

• This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes used in medical transcription and billing and for Level I HCPCS. www.ahacentraloffice.org

American Medical Association (AMA)

• This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Association for Electronic Health-care Transactions (AFEHCT)

• AFEHCT is a health-care association dedicated to promoting the interchange of electronic health-care information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

• CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Healthcare Transactions and Code Sets Model Compliance Plan at www.cms.hhs.gov/default.asp?fromhcfadotgov=true.

• This site is the resource for information related to the Healthcare Common Procedure Coding System (HCPCS). www.cms.hhs.gov/MedHCPCSGenInfo/

Designated Standard Maintenance Organizations (DSMO)
• This site is a resource for information about the standard-setting organizations and transaction change request system. www.hipaa-dsmo.org

Health Level Seven (HL7)
• HL7 is one of several ANSI-accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. www.hl7.org

Health Safety Net Office
• The Health Safety Net Office Web site assists providers with HIPAA billing and policy questions, as well as provider enrollment support. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/07/hsntf_rec_policies_fy2008.pdf

National Council of Prescription Drug Programs (NCPDP)
• The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)
• NUBC is affiliated with the American Hospital Association and develops standards for institutional claims. www.nubc.org

National Uniform Claim Committee (NUCC)
• NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)
• OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

Sends / iNet
• The Sends/iNet process is a double-encrypted, secure method of transmitting health care information and data. Call 1-800-609-7232 to discuss how to load this software.

United States Department of Health and Human Services (DHHS)
• The DHHS Web site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)
• WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

• WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org

Appendix D: MA-9 Form Locator to 837 Element Crosswalk

The Crosswalk is included to help Providers identify the legacy Record Type and Field to the MA-9 and/or ADA. The 837 Section is presented as a general guide as many Form Locators on either form are not required elements for the HSN claims submission. Please see the 837D Implementation Specification v2.0 for corresponding Loops and Segments.

Health Safety Net 837D Companion Guide v2.0